UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF NORTH CAROLINA

FOSTER EZELL STEEN, Plaintiff, vs. UNITED STATES OF AMERICA (USA), Defendant.	)	Civil Action No. 1:22-cv-406

COMPLAINT

COMES NOW the Plaintiff, Foster Ezell Steen, by and through his attorney, Gregory M. Kash of the Law Offices of Gregory M. Kash of Raleigh, North Carolina, and states the following as his cause of action against the Defendant United States of America (USA).

PARTIES, JURISDICTION SERVICE OF PROCESS AND VENUE

1. At all relevant times, Plaintiff Foster Ezell Steen is and was mentally competent, not in military service, *sui juris,* was a citizen and resident of Gastonia, Gaston County, North Carolina.

2. The Defendant is the United States of America.

3. This Federal District Court has jurisdiction over this cause, as this action is brought pursuant to and in compliance with 28 U.S.C. §§1346(b), 2671-2680 et seq.,

commonly referred to as the "Federal Torts Claims Act," which vests exclusive subject matter jurisdiction of Federal Torts Claims litigation in the Federal District Court.

4. This claim arises out of the negligent medical care of Foster Ezell Steen (hereinafter "Plaintiff" or "Steen") at the W.G. Hefner Salisbury VA Medical Center located in Salisbury, North Carolina .

5. The United States of America may be served with process in accordance with Rule 4(i) of the Federal Rules of Civil Procedure by serving a copy of the Summons and Complaint on Sandra J. Hairston, Acting United States Attorney for the Middle District of North Carolina (MDNC), attention Civil Process Clerk, at 101 South Edgeworth Street, 4th Floor, Greensboro, NC 27401 by certified mail, return receipt requested; and by serving a copy of the Summons and Complaint on Merrick B. Garland, Attorney General of the United States, United States Department of Justice, 950 Pennsylvania Avenue, NW, Washington, DC 20530-0001, by certified mail, return receipt requested.

6. Pursuant to 28 U.S.C. §§ 1391(b)(2), venue is proper in this district as the United States is a Defendant and because a substantial part of the events or omissions giving rise to this claim occurred in this district.

LIABILITY OF THE UNITED STATES OF AMERICA

7. This claim is commenced and prosecuted against the United States of America pursuant to and in compliance with 28 U.S.C. §§ 2671-2680 et seq., commonly referred to as the "Federal Torts Claims Act" (FTCA). Liability of the United States is predicated specifically on Title 28 U.S.C. §§ 1346(b)(1) and 2674 because the personal injuries and resulting damages of which complaint is made, were proximately caused by

the negligence, wrongful acts and/ or omissions of employees of the United States of America at the W.G. Hefner Salisbury VA Medical Center (VAMC) located in Salisbury, North Carolina, while acting within the scope of their office or employment, or acting with apparent authority, under circumstances where the United States of America, if a private person, would be liable to Plaintiff in the same manner and to the same extent as a private individual.

JURISDICTIONAL PREREQUISITES UNDER FTCA

8. On or about August 6, 2018, Steen timely filed an administrative claim with the appropriate federal agency, the Department of Veteran's Affairs, pursuant to 28 U.S.C. §§ 2401(b), 2675.

9. On June 4, 2020, the Department of Veteran's Affairs issued a denial of the Plaintiff's administrative claim.

10. On October 7, 2020, Steen, by and through counsel, requested with the appropriate federal agency, the Department of Veteran's Affairs, reconsideration of the decision to deny his Federal Tort Claim.

11. On December 3, 2021, the Department of Veteran's Affairs, by and through Jennifer Hansen, Deputy Chief Counsel, issued a letter in which the Plaintiff's reconsidered claim was again denied.

12. This Complaint has been filed within six (6) months from the denial of the Plaintiff's administrative claim, pursuant to 28 U.S.C. § 2401(b).

THE DEPARTMENT OF VETERANS AFFAIRS IS AN AGENCY OF THE UNITED STATES OF AMERICA

13. The Department of Veterans Affairs is an agency of the United States of America. At all relevant times, Defendant United States of America (USA), through its agency, the Department of Veterans Affairs, owned, operated, and controlled the health care facility known as the W.G. Hefner Salisbury VA Medical Center (VAMC) located in Salisbury, North Carolina. Defendant USA, by and through its agency, the Department of Veterans Affairs, staffed the VAMC with it agents, servants, apparent agents and/ or employees, and said agents, servants, apparent agents and/ or employees rendered the medical care and treatment in question to Plaintiff Palmer.

EMPLOYMENT AND COURSE AND SCOPE OF EMPLOYMENT

14. At all relevant times, all persons involved in the medical and health care services provided to Plaintiff Foster Ezell Steen at the W.G. Hefner Salisbury VA Medical Center (VAMC) located in Salisbury, North Carolina, were the agents, servants, apparent agents and/or employees of the Department of Veterans Affairs, the United States of America, or some other agency thereof, and at all material times, were acting within the course and scope of their employment or agency.

NORTH CAROLINA MEDICAL MALPRACTICE PREREQUISITES

15. At all the relevant times, Kevin Whittington Watson, MD (hereinafter "Dr. Watson"), was, upon information and belief, a medical doctor licensed to practice medicine in the State of North Carolina. Upon information and belief, Dr. Watson was a resident of Salisbury, Rowan County, North Carolina. At all relevant times, Dr. Watson practiced in

the specialty of general surgery and worked as a staff physician at VAMC, was employed by VAMC, was an apparent agent of VAMC, and was an employee and agent of Defendant USA. Dr. Watson, at all times relevant to Plaintiff's Complaint, worked at the Salisbury VAMC and formed a doctor-patient relationship with Plaintiff, and was actively involved as the attending physician or consulting physician, and was one of the physicians tasked with primary responsibility for the Plaintiff's care during the course of his medical care received at VAMC from May 21, 2018 through June 1, 2018, and thereafter.

16. At all the relevant times, Godfredo Igno Garcia, MD (hereinafter "Dr. Garcia"), was, upon information and belief, a medical doctor licensed to practice medicine in the State of North Carolina. Upon information and belief, Dr. Garcia was a resident of Salisbury, Rowan County, North Carolina. At all relevant times, Dr. Garcia practiced in the specialty of internal medicine as a hospitalist and worked as a staff physician at VAMC, was employed by VAMC, was an apparent agent of VAMC, and was an employee and agent of Defendant USA. Dr. Garcia, at all times relevant to Plaintiff's Complaint, worked at the Salisbury VAMC and formed a doctor-patient relationship with Plaintiff, and was actively involved as the attending physician or consulting physician, and was one of the physicians tasked with primary responsibility for the Plaintiff's care during the course of his medical care received at VAMC from May 21, 2018 through June 1, 2018, and thereafter.

17. At all relevant times, Defendant USA was vicariously liable for the actions and/or omissions of Dr. Watson and Dr. Garcia, as well as the unnamed agents and employees of VAMC described herein, as these named and unnamed employees, agents,

apparent agents, or servants functioned with actual and/ or apparent authority as the employees or agents of Defendant USA acting within the scope of their employment or agency. Defendant USA is therefore liable under respondeat superior, master-servant or agency for the acts or inactions of the agents and employees described herein.

18. At all relevant times, Defendant USA, by and through VAMC, and Dr. Watson and Dr. Garcia, were healthcare providers as defined by N.C. Gen. Stat. § 90-21.11 and were healthcare providers to Plaintiff. This action alleges "medical malpractice" by "health care provider(s)" as defined in N.C. Gen. Stat. § 90-21.11 in failing to comply with the standards of care pursuant to N.C. Gen. Stat. § 90-21.12.

19. Pursuant to Rule 9(j) of the North Carolina Rules of Civil Procedure, the medical care which is the subject of this Complaint and all medical records pertaining to the alleged negligence that are available to the plaintiff after reasonable inquiry have been reviewed by physicians who Plaintiff reasonably believes and expects will qualify as an expert witnesses under Rule 702 of the North Carolina Rules of Evidence, are currently in the active practice of general surgery and internal medicine/ hospitalist and are familiar with the applicable standard of care in Salisbury, Rowan County, North Carolina or similar communities. These medical care providers are willing to testify that the medical care complained of did not comply with the applicable standards of care.

PLAINTIFF'S OBJECTIONS TO N.C.G.S. § 90-21.19

20. Plaintiff objects to N.C.G.S. § 90-21.19 ("The Cap on Non-Economic Damages") as unconstitutional. The Cap On Non-Economic Damages denies medical malpractice plaintiffs, including Plaintiff in this action, the right to a jury trial, due process

of law, equal protection under the law and the right to open courts, violates the separation of powers, and confers that exclusive emolument on healthcare providers, in violation of the United States and North Carolina Constitutions. The Cap on Non-Economic Damages violates the Seventh and Fourteenth Amendments of the United States Constitution and Article I, Sections 6, 18, 19, 25 and 32 and Article IV, Sections 1 and 13 of the North Carolina Constitution.

FOSTER E. STEEN HISTORY AND BACKGROUND

21. Foster Ezell Steen ("Steen") was born in Evergreen, Conecuh County, Alabama in 1943. Mr. Steen attended elementary and junior and high school in Conecuh County, completing high school at Conecuh County Training School in Evergreen, Alabama in 1962.

22. After graduating high school, Steen moved to Los Angeles, California where he lived for a short period of time until entering the United States Army on June 14, 1966. Steen attended basic training at Fort Bliss, Texas, and advanced training at Fort Leonard Wood, Missouri. Mr. Steen's first permanent duty assignment was in Baumholder, Germany. He was assigned to the 293nd Engineer Battalion, where he remained until June 1, 1968. Steen was then transferred to South Vietnam where he was assigned to the 70th Combat Engineer Battalion, where he was stationed in the Central Highlands of Vietnam. Steen participated in live combat action in Vietnam on multiple occasions while his engineering battalion provided project services to various bases within Vietnam.

23. Steen returned to the United States from Vietnam on June 1, 1969, and married his wife, Delores Lindsey Steen, on June 21, 1969. Steen continued with the United

States Army at the Yuma Proving Grounds in Arizona until 1970. Steen was honorable discharged from the United States Army in 1970 as a Specialist E-5. Steen then relocated to Gastonia, North Carolina.

24. When arriving in North Carolina, Steen had employment at HomeLite manufacturing chainsaws, Martin Marietta as an electrician and then for the North Carolina Department of Corrections where he worked for between 29-30 years, rising to the rank of Assistant Superintendent, retiring in 2002.

25. Steen also joined the North Carolina Army National Guard in 1977, and was assigned to the 2nd Battalion 252 Armor Division - where he participated in annual training at Fort Hood, Texas; Fort Knox, Kentucky; Fort Bragg, North Carolina and numerous other sites. Mr. Steen advanced to the rank of Platoon Sergeant, retiring in 1996.

26. Since his retirement Mr. Steen and his wife enjoyed travelling, gardening, Church activities, family events and relaxing in Steen's days of retirement.

27. Mr. Steen is still married to Delores Lindsey Steen, with 53 years of marriage between them. From the Steens' marriage, they have one child, Terrence Steen, and grandchildren.

28. Prior to the events described in this lawsuit, Mr. Steen was a relatively healthy, but obese gentleman. He was active, capable of walking long distances, capable of working in his yard, shopping, and performing general household repairs and upkeep. Steen was actively engaged in life, life's activities and enjoying retirement with his wife, spending time with his child and grandchildren. Shortly before the events of this lawsuit,

Mr. Steen had vacationed with his family in Birmingham, Alabama, where the family had travelled to state parks, museums, and historical sites, requiring extensive walking.

29. Among his many civic activities, Steen served as the Chapter Commander of the National Association for Black Veterans for two and a half years. This group focused on assisting veterans of all races with obtaining benefits they may be owed through the Veteran's Administration.

30. Since the events of this lawsuit, Mr. Steen's physical abilities have been significantly diminished as described more fully herein.

MEDICAL BACKGROUND ON RIGHT HEMICOLECTOMY, ANASTOMOSIS AND RISKS OF ANASTOMOTIC LEAK

31. A hemicolectomy is a type of surgery done to remove part of the large intestine, the colon. Portions of the colon can be removed with minimal effect on the digestive system. Once the affected part is removed, the remaining ends are joined together with almost no impact on the digestive tract. A right hemicolectomy involves removing the right side of the colon and attaching the small intestine to the remaining portion of the colon.

32. An anastomosis, in this setting, is the surgical reconnection of the two remaining parts – in the Steen case the small intestine to the colon – which are anastomosed, or joined together, by surgical stich or staple.

33. An anastomotic leak occurs when a surgical anastomosis fails and contents of a reconnected body channel leak from the surgical connection. It's one of the most serious complications of bowel resection surgery, a portion of the surgery encountered by

Steen. In the setting of a bowel resection and anastomosis, a leak is serious because the colon and small intestine carry fecal matter that do not belong in the open abdominal cavity. Fecal matter in the gastrointestinal tract contain bacteria that can infect the abdominal cavity if they leak out.

34. When bowel contents leak into the abdominal cavity, they can cause infection and inflammation of the peritoneum, the tissue that lines the abdominal cavity, a condition known as peritonitis. Infection in the abdomen can spread to other abdominal organs and can enter the bloodstream. Bloodstream infections are bacteremias when the infections are bacterial, and fungemias when the infections are fungal, and are infections present within the blood. Serious infection can lead to sepsis, which is a life-threatening physical immune system reaction that can include shock, organ failure or death.

35. The normal in-patient recovery for a patient undergoing hemicolectomy with anastomosis is five days, with the patient gradually returning to baseline by clinical presentation and labs.

VAMC MEDICAL CARE OF MR. STEEN FROM MAY 21, 2018 THROUGH JUNE 1, 2018

36. On May 21, 2018, Steen was a 74-year-old black male. His medical records indicate that Mr. Steen had a medical history that included prostate cancer, diabetes, loss of an eye, PTSD, chronic kidney disease, sleep apnea, colon polyps, hypertension, and hyperlipidemia. Steen's prostate cancer had been determined to be 60% service connected, his diabetes 2% service connected and his PTSD 100% service connected.

37. On April 12, 2018, Steen had undergone at the VAMC a colonoscopy performed by Dr. Lorenz Rowe. The findings of the colonoscopy showed a single polypoid sessile polyp measuring between 10 millimeter and 20 millimeters found in the hepatic flexure. Biopsy was obtained and the area was marked with tattoo ink. The colonoscopy found a large polypoid tumor in the ascending colon. That area was marked with tattoo ink and biopsied as well. A sessile polyp measuring between five millimeters and ten millimeters was found in the cecum and biopsied. Two sessile polyps measuring between five millimeters and ten millimeters were found in the transverse colon. The remaining segments of the colon were found to be normal.

38. On May 21, 2018, Steen presented to the VAMC to undergo a robotic and hand assisted right hemicolectomy to be performed by Dr. Kevin Watson. On or about 0806 hours, Dr. Watson performed the robotic and hand assisted right hemicolectomy which was performed robotically and manually through an open midline incision. The terminal ileum and the ileocolic pedicle were transected. A seven-centimeter incision made in the upper abdominal midline to remove the hepatic flexure. The proximal transverse colon and the terminal ileum and a small segment of the transverse colon were resected and removed. The remaining terminal ileum and transverse colon were closed by performing a side-to-side anastomosis using a staple gun. The common enterotomy was closed using a running 000V-Lock 180 suture. The closure was reinforced with multiple interrupted 000 silk seromuscular sutures. All the port openings and the midline incision were sutured close and covered with a Dermabond dressing. Operating time for the

procedure was from 0840 to 1429 hours. The wound was classified as a contaminated wound based upon the procedure performed.

39. On May 21, 2018 there is a 1550 hours nursing note reflecting Steen's vitals were 173/77-89-18-98.1-97%. Steen's weight was noted to be 300 pounds at that time. The nursing note reflects that Steen was admitted for a right hemicolectomy. Steen was noted to have a peripheral IV in the right hand and was with nasal canula oxygen at two liters. Steen was NPO.[1] The nursing note reflects that Steen's abdomen was distended and tender and that he had hypoactive bowel sounds in four quadrants. Steen's last bowel movement was noted to be on 05/20/18. Steen was without nausea or vomiting. Steen was noted to have a Foley catheter in place and was placed on a strict Intake and Output regimen. The nursing notes reflect that Steen had four laparoscopic sites closed with Dermabond with no drainage noted from the incision sites.

40. On that same date, there is a 1642 hours physician note of Abinet Boku, M.D., an internist/hospitalist, noting that Mr. Steen was admitted under the surgical service having undergone a laparoscopic assisted right hemicolectomy for a colon mass found during a prior colonoscopy. Steen denied pain and looked comfortable according to Dr. Boku. Dr. Boku described Steen's midline incision and that he was with active bowel sounds. Dr. Boku described a Foley catheter in place, noting to continue CPAP and home blood pressure medications. Dr. Boku charted in his assessment that he would consider Steen's chronic kidney disease and would discontinue KCL (potassium chloride) in Mr.

[1] NPO means "nothing by mouth," from the Latin *nil per os*, medical shorthand for a period of time in which a patient may not eat or drink anything.

Steen's IV fluids since his potassium level was at 4.3. Dr. Boku indicated that he would follow this.

41. On the same date there is a 1730 hours nursing note reflecting that telemetry was initiated due to Steen having random episodes of sinus rhythm with PVCs (premature ventricular contractions) and PACs (premature atrial contractions).

42. On the same date there is a 2347 hours nursing note reflecting urine output of 700 milliliters with no bowel movements.

43. On May 22, 2018, nursing notes at 0318 hours reflect Steen had Foley output of 700 milliliters or urine. No bowel movements were reported at that time.

44. On the same date at 0654 hours nursing notes reflect Steen's Foley catheter was removed. On the same date at 0700 hours labs were reported showing the following abnormal findings: K = 5.1H, Cl = 113H, BUN = 25H, Cr = 1.90H and GLU = 294H and Ca= 7.8L.

45. On the same date at 0704 hours there is a surgical pathology note reflecting that the right colon and remainder of hepatic fissure removed by Dr. Watson on 05/21/18 was received in the Pathology Lab at VAMC.

46. On the same date at 0722 hours nursing notes reflects urine output of 600 milliliters with no bowel movements. On the same date at 0830 hours vital signs are recorded as 169/81-98-18-98.5-96%. Steen's pain score was noted to be a 7/10.

47. On the same date at 0952 hours Tong Li-Masters, M.D., internist-hospitalist, charts that Mr. Steen was doing well with pain relatively controlled. Dr. Li-Masters found no shortness of breath, fever, chills, or chest pain. Dr. Li-Masters noted Steen's abdomen

to be soft, tender but non-distended. Dr. Li-Masters charts to hold Steen's home meds, noting Steen's Creatinine is worse. Dr. Li-Masters noted that he will start IV Metoprolol for better blood pressure control. Nursing notes at that time as well indicate Steen's pain to be seven out of ten but that he refused pain medication. Blood pressure was noted to be 169/81 at that time with a heart rate of 98. Nursing charts Metoprolol given. Nursing also documents that Steen denied shortness of breath.

48. On the same date at 1012 hours, Christopher McIltrot, M.D., general surgeon, was covering for Dr. Kevin Watson. Dr. McIltrot notes that Steen was voiding spontaneously and was ambulatory. Dr. McIltrot felt Steen's pain was controlled, that he was afebrile and noted to be less hypertensive than earlier in the morning. Dr. McIltrot noted Steen's urine output of 700 milliliters, and documented that Mr. Steen's incisions were well healed. Dr. McIltrot noted that Steen's abdomen was softly distended and appropriately tender. Dr. McIltrot also noted Steen to be on telemetry. Dr. McIltrot noted in his assessment – expected ileus[2]. Dr. McIltrot also indicated that Steen was capable of having sips of water or ice chips.

49. On the same date at 1104 hours nursing notes reflect Steen's blood pressure at 127/77 with a heart rate of 96. Nursing notes reflect that Steen ambulated in the hallway and that he voided 150 milliliters of urine. Steen was still NPO at that time. Nursing notes reflect no bowel movements had occurred at that time.

[2] An ileus is the inability of the intestine to contract normally leading to a buildup of food materials within the intestine. An ileus is an expected complication of a hemicolectomy with anastomosis.

50. On the same date at 1459 hours nursing notes reflect that Steen voided 600 milliliters of urine. No bowel movements were recorded at that time. Steen was still NPO. Steen was noted to be ambulating with assistance.

51. On that same date at 2344 hours nursing notes reflect that Steen voided 200 milliliters of urine. No bowel movements are noted at that time. Steen was noted to be ambulating, and Steen was still recorded at NPO, except for ice chips.

52. On May 23, 2018 at 0235 hours nursing notes reflect that the patient has four laparoscopic sites and a midline abdominal incision with no signs of infection. Nursing notes reflect hypoactive bowel sounds. No bowel movements charted, although Steen was noted to have voided 1600 milliliters of urine.

53. On the same date at 0700 hours labs are reported with the following values being outside a range of normal: WBC = 14.6H, W/Bandemia, H/H = 9.9L/32.0L[3], Cr = 1.490H, Glu = 216H, Cl = 114H and CO2 = 18L, Ca = 8.2L.

54. On the same date at 0825 hours nursing notes reflect vital signs of 130/69-75-18-99.9.

55. On the same date at 0954 hours Dr. Li-Masters, internist-hospitalist, charts Steen is doing okay with no fever, chills, shortness of breath. Dr. Li-Masters felt that Steen's pain was controlled, and Steen had had no flatus or bowel movement. Dr. Li-Masters charted Steen's midline incision was clean and dry and charted an increase in

[3] H/H is a medical abbreviation for hemoglobin/hematocrit.

Metoprolol by IV for better blood pressure control. Dr. Li-Masters charted to continue CPAP and to encourage ambulation.

56. On the same date at 1022 hours Dr. Watson's progress note charts an uneventful night, that Steen is still NPO and with no flatus. Dr. Watson charted Steen's abdominal incisional discomfort improving, and that Steen was voiding. Dr. Watson charted that Steen had a little nausea this AM and notes more distention [of the abdomen]. Dr. Watson felt Steen to be overall stable, with NPO due to ileus. Dr. Watson charted that he would consider an NG tube if nausea or distention worsens. Dr. Watson charted Steen was with low grade fever and slightly elevated WBC of 14,000 likely due to atelectasis[4]. Dr. Watson charted that Steen was to use Inspirometer and to ambulate in the halls tid with assistance. Dr. Watson charts that Steen's Po4 [phosphorus] is being replaced by medicine. Dr. Watson charts that he appreciates medicine assisting with the management of HTN/BG [hypertension/blood glucose].

57. On the same date at 1521 hours, nursing notes reflect that Steen voided 300 milliliters and that he ambulated twice in the hall. Steen was still NPO.

58. On the same date at 1529 hours, nursing notes reflect that Steen's abdomen is distended, that he has hypoactive bowel sounds, further charting that Steen had no bowel movements since surgery.

59. On the same date at 2050 hours, nursing notes reflect that Steen's abdomen is soft and non-tender, with normal bowel sounds and that he is voiding.

[4] Atelectasis is a condition where lungs collapse partially or completely. Mild cases of atelectasis show no signs or symptoms, but might develop into breathing difficulties upon worsening. Severe cases of atelectasis require urgent medical attention and may be life threatening.

60. On the same date at 2347 hours, nursing notes reflect that Steen is NPO, has voided 400 milliliters, and has had no bowel movements.

61. On May 24, 2018 at 0700 hours, labs are reported for Steen with the following values being outside a range of normal: WBC = 14.27H W/Bandemia, H/H = 10.6L/34.6L, Cr = 1.640H, BUN = 27H, Glu = 163H, Cl = 116H and CO2 = 21L.

62. On the same date at 0815 hours, nursing charts vital signs as follows: 162/90-83-18-97.6F – 97%. Steen's pain is recorded as a 3/10 at that time.

63. On the same date at 1001 hours, Dr. Li-Masters charts that Steen has been ambulating but no bowel movement or much flatus yet. Telemetry that morning reflected PVCs with short runs of bigeminy.[5] Dr. Li-Masters charted Steen's abdomen was soft but distended. Dr. Li-Masters's impression was of post-op ileus, charting Steen's Metoprolol IV, and to hold home htn meds. Dr. Li-Masters charted the need for an ECHO and to obtain a cardiac consult for Steen's frequent PVCs. Dr. Li-Masters charted the need to check and replace electrolytes as needed, and to increase IV fluids and to encourage ambulation.

64. On the same date at 1203 hours, nursing charts vitals as follows: 149/72-88-18-99.6.

65. On the same date at 1318 hours, Dr. Watson's progress note reflects Steen was with small amount of flatus that morning, nausea having resolved and pain well controlled. Dr. Watson charted that Steen was without chest pain or shortness of breath,

[5] The characteristic sound of the heartbeat comes from the valves between the chambers opening and closing as blood circulates through the heart. When the timing gets skewed, the rhythm gets skewed. The technical term for this is arrhythmia. There are many forms of arrhythmia, including bigeminy. **Bigeminy** is a type of heart arrhythmia in which the heart beats once normally and once abnormally in quick succession, followed by a pause.

and that Steen had been ambulating in the hallway and was much improved. Dr. Watson charts Steen as still being NPO, and with abdomen remaining distended and appropriately tender. Dr. Watson charts that surgical pathology report is pending, and charted to be hopeful that ileus is beginning to resolve. Dr. Watson indicated that he may consider starting clear liquids later that day. Dr. Watson charts WBC = 14,000 (stable), Hgb = 10 (stable) and electrolytes were okay.

66. On the same date at 1422 hours, Steen is charted as being seen by Dr. Katherine Card, as a cardiology consult for Steen's PVCs. Dr. Card notes that Steen has no prior cardiac history and he is POD3 (post-operative day 3) status post-hemicolectomy due to a suspicious polyp. Dr. Card notes that Steen's telemetry exhibited intermittent PVCs and PACs and bigeminy with no associated cardiac symptoms. Dr. Card notes that Steen is currently on Metoprolol, that telemetry shows normal sinus rhythm with intermittent PVCs and PACs with infrequent bigeminy. No V-Tach. Dr. Card's assessment and plan reflected her thoughts that his cardiac problems may be related to untreated sleep apnea. Dr. Carr suggested continued telemetry, CPAP, IV hydration and to monitor electrolytes. Dr. Card indicated that she would obtain an ECHO and would discuss further if the ECHO was abnormal. Dr. Card indicated no further cardiac testing necessary at that time.

67. On the same date at 1541 hours, nursing notes reflect that Steen voided 450 milliliters of urine, had no bowel movements, that he was NPO and he was ambulating on an ad lib basis. Nursing notes also reflect at this time that patient had ventricular bigeminy and that Dr. Li-Masters had been made aware.

68. On the same date at 2340 hours, nursing notes reflect that Steen is still NPO, that he is ambulating on an ad lib basis, had voided 300 milliliters of urine and had no bowel movements.

69. On May 25, 2018 at 0234 hours, nursing notes reflect that Steen voided 975 milliliters of urine and had not incurred any bowel movements. Nursing notes reflect Steen's abdomen as soft and distended. Notably, nursing notes reflect that bowel sounds were absent.

70. On the same date at 0718 hours, Dr. Li-Masters charts by progress note that Steen is still bloated. This note reflects that nurses reported that Metoprolol was held last night because of HR of 50. Steen's true pulse was 90-100 on telemetry. Dr. Li-Masters notes that he educated the nurse about true pulse rate in bigeminy. Will increase Metoprolol IV for frequent PVCs. Still to hold home htn meds. Dr. Li-Masters charted the ECHO consult. Again, Dr. Li-Masters notes that Steen should have his electrolytes monitored and replaced as needed. Dr. Li-Masters noted to continue CPAP and encourage ambulation.

71. On the same date at 0722 hours, nursing notes reflect that Steen voided 300 milliliters of urine, and no bowel movement had occurred.

72. On the same date at 0732 hours, labs were entered with the following lab results being out of normal range: NA = 147H, Cl = 117H, CO2 = 21L, Ca = 8.3L, BUN = 28H, Cr = 1.59H, Glu = 136H and Alb = 2.3L.

73. On the same date at 1129 hours, nursing notes reflect that Steen's abdomen was soft, distended and tender. Nursing charts that Steen has no bowel movement and with hypoactive bowel sounds.

74. On the same date at 1146 hours, Dr. Kevin Watson enters a progress note in which he documents no changes from yesterday. Dr. Watson notes no flatus, bowel movements, nausea, or vomiting. It is charted that Steen was tolerating sips of water. It was further charted that Steen was having appropriate incisional pain that is well controlled with Oxycodone. Dr. Watson noted that Steen's urine output at 975 milliliters and that Steen's abdomen remained distended. Steen's port sites were charted to be intact and without complication. Dr. Watson's assessment at this time was of ileus. Dr. Watson charts that Steen is still distended so to hold off on advancing diet, noting that he was drinking water. Dr. Watson notes that Steen had mild hypernatremia. Dr. Watson charted to change IV fluids to .45 normal saline and lower his IV rate. Dr. Watson noted that Dr. Shim will be on call and covering for him this weekend.

75. On the same date at 1311 hours, there is a dietary charting that notes the patient is post-op ileus status-post right hemicolectomy. Steen's weight was charted at 300 pounds with volume mass index of 45.7%. Dietary technician notes that Steen's abdomen is distended. It is charted that Steen has had no bowel movement yet but feels like he may have the urge soon. Dietary charts that IV fluids were switched to .45% normal saline. Steen was charted by dietary to be NPO but patient encouraged to drink sips of water and ice chips.

76. On the same date at 1535 hours, nursing notes reflect that Steen is still NPO. Nursing charts Steen voided 300 milliliters of urine that shift. Steen was without bowel movement.

77. On the same date at 1559 hours, cardiologist Joseph Hodgkiss, M.D. enters the ECHO interpretation in which he notes that there is severe asymmetrical septal left ventricular hypertrophy and moderate concentric left ventricular hypertrophy. EF = 70%. Mitral valve and tricuspid value are not well visualized. RV systolic pressure cannot be accurately estimated.

78. On the same date at 2015 hours, nursing notes noted Steen to be with bowel sounds hypoactive in all quadrants. This nursing note reflects last bowel movement was on 05/21/18.[6]

79. The Memorial Day weekend in 2018 was on Saturday May 26, 2018, Sunday May 27, 2018 and Monday, Memorial Day, May 28, 2018.

80. On May 26, 2018 at 0001 hours, nursing notes reflect Steen had no bowel movements during that shift. Urine output on that shift was noted at 2,160 milliliters plus five unmeasured voids within the last 24 hours.

81. On the same date at 0040 hours, nursing notes reflect that peripheral IV in the right hand discontinued due to infiltration. A new IV was charted to be difficult to restart. Nursing notes reflect that an ICU nurse was called and the IV restarted in the left hand by the ICU nurse.

82. On the same date at 0700 hours, labs were entered showing the following abnormal results: Cr = 1.98H, BUN = 37H, Glu = 156H, Cl = 116H, CO2 = 18L and Ca = 8.3L.

[6] Nursing notes on the day of surgery, 05/21/18, reflect that Steen's last bowel movement was actually on 05/20/18 and that he had not had a bowel movement since his surgery on 05/21/18.

83. On the same date at 0731 hours, nursing notes reflect Steen was still NPO except for ice chips. Urine output at that time was noted to be 150 milliliters of dark amber urine. No bowel movements noted on that shift.

84. On the same date at 0800 hours, nursing notes reflect vital signs as follows: 139/64-60-20-97.8-94%.

85. On the same date at 0909 hours, Dr. Shim, general surgeon, charted a progress note. Dr. Shim noted Steen to be stable overnight with persistent ileus. Dr. Shim charts that Steen had passed gas x 2, that Steen's abdomen was distended but with normal bowel sounds.

86. On the same date at 1058 hours, Dr. Li-Masters charts that Steen was in normal sinus rhythm, and PVCs are less frequent. Dr. Li-Masters charts that Steen has not had a bowel movement but has passed gas. Dr. Li-Masters encouraged ambulation, continued IV Metoprolol for frequent PVCs, continued CPAP and increase fluids and add bicarb for acidosis and worsening creatinine.

87. On the same date at 1554 hours, nursing notes reflect Steen had bowel movement today x 1. Nursing notes reflect that Steen had been up ambulating to his chair x 2, that he was still NPO and that Steen voided x 3 that day.

88. On the same date at 1933 hours, nursing notes reflect that Steen had three bowel movements during that shift and that he had been up ambulating in the hall. Nursing charts that Steen was medicated for abdominal pain x 1. Telemetry reflected Steen in sinus rhythm with PVCs.

89. On the same date at 2359 hours, nursing notes reflect that Steen voided 200 milliliters of urine plus two unmeasured. Steen was charted as having one bowel movement during this shift. Steen is still charted as being NPO.

90. On May 27, 2018 at 0100 hours, nursing notes reflect vital signs as follows: 148/74-93-20-98.2-94%.

91. On the same date at 0620 hours, Dr. Li-Masters provides by progress note that Steen was doing better, had three bowel movements and HR and BP controlled. Steen was felt to be with less PVCs. Steen's abdomen was charted as being soft, less distended, no tenderness and with positive bowel signs. Dr. Li-Masters changed Metoprolol to PO, still holding home htn medicines. Dr. Li-Masters requested cardiology consult for Steen's PVCs, continuing CPAP and encouraging ambulation.

92. On the same date at 0808 hours, nursing notes reflect that Steen is still NPO, and voided 400 milliliters of urine. Nursing notes reflect that Steen had one bowel movement that day.

93. On the same date at 0937 hours, Dr. Shim enters a progress note in which he notes Steen had multiple bowel movements yesterday. Dr. Shim charts Steen's abdomen has still distended but less than yesterday. Dr. Shim felt Steen had normal bowel sounds, and improving ileus. Dr. Shim ordered decreased IV fluids, a clear liquid diet and charted that Dr. Watson was to follow with the patient in the am.

94. On the same date at 1513 hours, nursing notes reflect that Steen had two large loose stools today and that he had voided 100 milliliters of urine x 2. Steen was noted to

have tolerated a clear liquid lunch. PO = 840 mls (oral intake). Steen was noted to be out of bed to his chair.

95. On May 28, 2018 at 0002 hours, nursing notes reflect Steen voided 500 milliliters of urine and had three loose stools. Nursing charts Steen to be out of bed in chair x 1. Nursing charts PO = 480 mls and IV = 320 milliliters.

96. On the same date at 0015 hours, nursing notes reflect Steen's PO = 1,320 mls and IV = 1,195 mls. Steen was noted to have voided 1,050 milliliters plus to have been to the bathroom x 2 unmeasured. Steen was also charted to have six bowel movements.

97. On the same date at 0628 hours, Dr. Li-Masters charts that Steen is doing okay, tolerating clear liquids, and had multiple bowel movements today. Dr. Li-Masters notes to continue Metoprolol PO, discontinue home BP meds, to obtain cardiology consult for frequent PVCs, continue CPAP, and encourage ambulation. Nurses were instructed to monitor electrolytes and replace as needed.

98. On the same date at 0643 hours, nursing notes reflect recovering ileus, and patient with multiple loose bowel movements last night. Steen was noted to be tolerating a clear liquid diet and that his pain was controlled with Oxycodone. Nursing charts Steen's abdomen is distended but slightly improving since yesterday.

99. On the same date at 0700 hours, labs were entered with the following abnormal findings: Cr = 1.85H, BUN = 41H, Glu = 189H, Cl = 116H, CO2 = 18L, Ca = 8.2L, H/H = 9.8L/30.4L, RDW = 19.1H and WBC – 8.0.

100. On the same date at 1536 hours, nursing notes reflect that Steen voided 600 milliliters of urine and had one bowel movement today. Steen was noted to be out of bed in his chair x 1. PO = 780 mls.

101. On the same date at 2310 hours, nursing notes reflect Steen to be incontinent. Nursing notes reflect that Steen voided 100 milliliters of urine, plus the bathroom x 2 unrecorded. PO = 600 mls. Urine = 100 mls.

102. On May 29, 2018 at 0014 hours, nursing notes reflect that Steen's abdomen is soft, he is with normal bowel sounds with last bowel movement on 05/28/18. Steen is noted to be voiding.

103. On the same date at 0338 hours, nursing notes reflect PO intake of 1500 milliliters, IV intake of 1469 milliliters. There is noted that Steen has voided twice and also with two bowel movements.

104. On the same date at 0721 hours, nursing notes reflect Steen encouraged to ambulate, that Steen slept well during the night and medicated once between.

105. On the same date at 0800 hours, Elisabeth Smith, M.D., a Surgeon Service Student, presumably a resident or fellow, charted a progress note. Dr. Smith noted that Steen was resting comfortably and had flatus and bowel movements over the weekend. Dr. Smith's consult note reflects the most recent bowel movement was at 2200 hours. Steen was noted to be tolerating a liquid diet, ambulating multiple times during per day without difficulty, but still having some incisional pain which was well controlled with Oxycodone. Steen's PO intake was noted at 1500 milliliters and IV intake of 1469 milliliters. Dr. Smith's note reflects a discussion with PA Robert Alexander, who indicated his wishes to

hold Steen from advancing diet. Dr. Smith's charting indicates that she hopes that Steen will be ready from a surgical standpoint to be discharged tomorrow. Dr. Smith discussed her findings with Dr. Boku.

106. On the same date at 0911 hours, nursing enters the following vital signs: 149/68-84-24-98.2.

107. On the same date at 1134 hours, nursing notes reflect Steen's abdomen is soft, obese, and non-tender with normal bowel sounds in all quadrants. Steen was noted to be voiding.

108. On the same date at 1311 hours, Dr. Boku, internist-hospitalist, notes that Steen was examined and indicates that he feels the same. Steen's telemetry strips show many PVCs and bigeminy. Steen's lungs were decreased air entry at the bases bilaterally. Steen's respiration rate was charted to be 24, which was high. Steen's WBCs are 8,000, but he is noted with be with Bandemia. Dr. Boku's plan was to continue Metoprolol, hold diuretics, Losartan and ARB. Dr. Boku charts to continue telemetry and CPAP, get labs, EKG, cheat x-ray now. Dr. Boku requested cardiac consult and encouraged ambulation and to continue Lantus and SSI.

109. On the same date at 1401 hours, labs are entered with the following abnormal findings: WBC = 12.5H, H/H = 9.0L/28.7L, Cr = 2.45H, BUN = 44H, Glu = 211H, Cl = 114H, CO2 = 18L and Ca = 7.6L.

110. On the same date at 1407 hours, nursing notes reflect chest x-ray to rule out pneumonia by Dr. Boku.

111. On the same date at 1426 hours, PA-C Robert Alexander, of general surgery, charts by progress note that Steen was seen comfortably on the side of his bed without complaints. Steen indicated that he had not been ambulating regularly and continues to have watery bowel movements. Per nursing, Steen had had six in a 24 hour period. Steen indicated that he was tolerating liquids, but did wish to increase to solid foods at that time. Steen denied nausea or vomiting. Steen's PO intake was charted at 1500 milliliters and he was charted to have voided twice and having stool twice. PA-C Alexander noted Steen's abdomen to be protuberant and tender to palpation. Bowel sounds were positive. PA-C Alexander charted that he discussed this patient with Dr. Watson, and charted to continue clear liquids.

112. On the same date at 1507 hours, chest x-ray interpretations were posted by Dr. Julie Moyers, radiologist. The report noted attention needed – significant abnormality. Radiologist charted by report that there is new small to moderate white pleural effusion with mild cardiomegaly noted. Patch opacity in the left lung with peri bronchial cuffing. Dr. Moyers noted that if clinical findings are consistent with pneumonia, follow up radiographs are recommended to document the resolution of the left lung base densities.

113. On the same date at 1600 hours, Dr. Boku enters by progress note that Steen's creatinine is trending upward, with new pleural effusion, rising Bandemia and persistent acidosis despite bicarb drip. Dr. Boku's charted differential diagnosis suspected source of sepsis is pneumonia or abdomen due to recent surgery. Dr. Boku's plan consisted of labs-ABG, lactate, blood cultures. Start IV Azithromycin and Ceftriaxone. Dr. Boku charted a need for infectious disease and nephrology consults. Dr. Boku noted that transfer to the

ICU was not currently possible due to the ICU being full. Dr. Boku then talked with the ICU team who indicated that they would swap Mr. Steen with a patient in the ICU who had become stable. It was noted that Mr. Steen would be transferred to the ICU as soon as the bed became available. Dr. Boku also charted talking with Dr. Watson, who asked Dr. Boku to order a CT scan of the chest, abdomen, and pelvis to rule out an abscess.

114. On the same date at 1601 hours, labs resulted were reported with the following abnormal findings: pH = 7.39, PCO2 = 26L, PO2 = 48L, HCO3 = 15.7, L and 02 sat = 86.4%L.

115. On the same date at 1616 hours, nursing notes reflect vitals taken as follows: 161/81-55-38-101.4.

116. On the same date at 1620 nursing notes reflect that Steen's 02 sats were 83% by monitor. Steen was noted to be tachypneic[7] with temperature of 101.9. Nurses document that Dr. Boku notified of findings. Steen was denying pain at that time. Nurses chart that Mr. Steen still waiting for transfer to ICU bed. Nurses also chart that ABGs obtained.

117. On the same date at 1630 hours, nursing notes reflect that Dr. Boku was in to see Steen, charted that still waiting to transfer patient to an ICU bed.

118. On the same date at 1641 hours, nursing notes reflect that Steen voided x 2 and that Steen had three liquid stools that day. Nurses chart that Steen had clear liquids for breakfast and lunch with PO intake of 840 mls.

[7] Tachypnea is fast, shallow breathing and results from a lack of oxygen or too much carbon dioxide in the body. A person can experience tachypnea due to benign issues, such as exercise, or can result from underlying health conditions and illness. The normal breathing rate for an average adult is 12 – 20 breaths per minute.

119. On the same date at 11700 nursing notes reflect that Steen's 02 sats remain between 89% and 94% on six liters of oxygen. Steen was described as being alert but drowsy. Nursing documents that Steen was awaiting blood culture being drawn before patient is medicated for a fever, per order.

120. On the same date at 1800 hours nursing notes reflect that Steen arrived in the ICU and was placed on a cardiac monitor. Nursing charts that a CT scan of the chest, abdomen and pelvis was ordered by Dr. Boku.

121. On the same date at 1801 hours, Dr. Watson charts a progress note in which he indicates he was in to see Dr. Steen prior to his transfer to the ICU. Dr. Watson indicates that he discussed with Dr. Boku the day's events, the clinical condition and work ups concerning Steen. Dr. Watson charts that Steen was currently complaining of shortness of breath which started rather suddenly that afternoon, without chest pain or abdominal pain. It was charted that Steen had been tolerating clear liquids but having diarrhea/loose stools. Dr. Watson notes that Steen was voiding but unsure of urine output. Dr. Watson charted that Steen was incontinent which is not normal for him and that Steen was in mild distress as tachypneic. 02 sats were 92% at that time on two liters of oxygen per nasal cannula. Steen's pulse was 100 and his blood pressure was described as okay. Steen's abdomen incisions were intact and he was described as mildly distended but non-tender and no guarding. Steen was noted to still be NPO now. Dr. Watson noted that he would order a Foley catheter to monitor strict I&Os (intake and output). Dr. Watson acknowledged Dr. Boku's order for blood cultures and also indicates that a urine culture and nephrology consult are needed. Dr. Watson noted patient to be transferred to the ICU and patient should

be given IV hydration and broad-spectrum antibiotics ordered. Dr. Watson notes that this is a patient with rather sudden decline in clinical status with ARI, hypoxia and metabolic acidosis. Dr. Watson charts the x-ray findings of new small to moderate right pleural effusion with mild cardiomegaly, and with patchy opacity in the left lung base with parabronchial cuffing. Dr. Watson notes a clinical correlation regarding pneumonia is recommended. Dr. Watson notes the abdominal KUB X-ray shows no free air but air in the distal colon noted. Dr. Watson charts that he agrees with Dr. Boku but the clinical picture for Mr. Steen was consistent with sepsis and charts that they will obtain a chest, abdomen, and pelvic CT scan to rule out anastomotic leak or other abdominal source.

122. On the same date at 1810 hours, nursing notes reflect that a peripheral IV was started in Steen's left antecubital vein.

123. On the same date at 1820 nursing notes reflect that Dr. Watson was at the bedside to evaluate the patient. The patient was described as being incontinent with large watery brown stool.

124. On the same date at 1841 hours, radiology notes CT scan of the chest/abdomen/pelvis performed without contrast for SOB due to pneumonia and sepsis was ordered by Dr. Nityanand Gupta, on the medicine service .

125. On the same date at approximately 1920 hours, nursing notes reflect that patient returned from radiology to the ICU.

126. On the same date between 1924 and 1930 hours, Dr. Watson reviewed the Steen CT scan. Dr. Watson charted that he was still waiting for the report for the interpretation of the patient's CT scan by the night-radiologist. However, Dr. Watson could

see no acute intra-abdominal process to explain the patient's septic picture. Dr. Watson describes that the patient has signs of a mild ileus but he did not see any free air, fluid collections or evidence of obstruction. The anastomosis was clearly visualized by Dr. Watson and by his review, did not show any evidence of a leak. Dr. Watson noted that the patient's chest CT scan findings were consistent with pneumonia, and he felt that the patient's sepsis was likely due to pneumonia because he could not find any abnormalities on the CT scan of the abdomen/pelvis to explain why the patient has sepsis. Dr. Watson charted discussing his interpretations with the patient's CT scan with Dr. Lipshy, who was covering for surgery the evening of 05/29/18. Dr. Watson's interpretation of the CT scan was in error as shall be shown herein.

127. On the same date at 2000 hours, nursing notes reflect that Steen was on six liters of oxygen per nasal cannula. His respiratory rate at that time was described as being between 45 and 48, and Steen was complaining of pain to his left posterior flank. Nursing helped Steen to his bedpan.

128. On the same date at 2030 hours, nursing notes reflect that a Foley catheter inserted and 30 mls of clear dark amber urine obtained and sent to lab. Lab urinalysis report show the urine to be cloudy, with WBC = 6H, RBC = 28H and few bacteria.

129. On the same date at 2040 hours, nursing notes reflect that Dr. Garcia notified of patient's complaints of pain and ordered pain medicine. (It appears that internist-hospitalist Godofredo Igno Garcia, M.D. was Mr. Steen's acting internist-hospitalist during the evening hours of May 29, 2018.)

130. On the same date at 2050 hours there is a radiology interpretation of the CT scan of the chest/abdomen/pelvis without contract completed for shortness of breath due to pneumonia and sepsis. The CT scan was reviewed by the National Teleradiology Program by radiologist Andreia Grafton, MD in California. This radiology report had captions indicating that the report had significant abnormal findings. Dr. Grafton's report indicated that with the chest CT showed integral development of small white pleural effusion and findings consistent with the right lower lube pneumonia and atelectasis. Report showed narrowing of the trachea which may reflect tracheobrochomalicia. The interpretation of the abdomen found recent right hemicolectomy with ileocolic anastomotic sutures in the right upper abdomen, moderate amount of pneumoperitoneum especially in the right perihepatic region extending into the subdiaphragmatic region and tracking adjacent to the ileocolic anastomotic suture and along the right lateral abdominal wall with a moderate amount of free fluid in the right abdomen and in the pelvis. **Dr. Grafton charts that these findings may be postsurgical in etiology, however, an ileocolic anastomotic leak cannot be excluded on the current study, especially in the setting of sepsis**. **If there is a clinical concern for an anastomotic leak, correlation and a contract-enhanced CT of the abdomen and pelvis should be considered for further evaluation.** There are air-fluid levels in the small bowel and transverse colon that may represent a post-operative ileus; however, an evolving small and large bowel obstruction cannot be excluded. The pelvis interpretation showed that there is urinary bladder pitting which may be related to incomplete distention and trabecular hypertrophy; however, superimposed inflammatory or infectious cystitis or other mucosal/nurel process cannot be excluded.

Please correlate clinically with urinalysis. Brachytherapy seeds are within the prostate gland.

131. **This same radiology report lists Primary Diagnostic Code as "SIGNIFICANT ABNORMALITY, ATTN NEEDED, and lists a Secondary Diagnostic Code as "CRITICAL ABNORMALITY." This same report also charts by Andreia Grafton, M.D. that the significant abnormal findings were discussed with Dr. Godofredo Garcia with read back verification at 2040 hours (5:40 P.M Pacific Standard Time) on 05/29/18.**

132. At no point in the record does Dr. Garcia document the discussion held with Dr. Andrea Grafton of the significant abnormal CT findings, nor is it charted that Dr. Garcia contacted Dr. Watson to advise him of the significant abnormal findings of the CT scan. There was also no order entered by Dr. Garcia for a contrast-enhanced CT scan of the abdomen and pelvis for evaluation of the anastomotic leak.

133. On the same date at 2055 hours, nursing notes reflect that Steen was medicated with pain with two mg of IV morphine. It is charted that Steen tolerated PO sips of water.

134. On the same date at 2100 hours, nursing notes reflect that Steen remains tachypneic, that his 02 sats were down to 89% and RT notified to come to bedside.

135. On the same date at 2115 nursing notes reflect that Steen remains tachypneic, but 02 sats improving with BiPAP.

136. On the same date at 2130 hours, nursing notes reflect SBP (systolic blood pressure) in low 70s. Dr. Garcia notified. Normal saline bolus started. Metoprolol was continued.

137. On the same date at 2204 hours, lab results were posted with the following abnormal findings: ABGs-pH = 7.39, PC02 = 27L, PA02 = 83.0 and HC03 = 16.3L.

138. On the same date at 2245 hours, nursing notes reflect Dr. Garcia was in to examine the patient and that ABGs drawn RT.

139. On the same date at 2302 hours, Dr. Godofredo Garcia charts a progress note showing that Steen was seen in the ICU where his ABGs at 1600 hours showed hypoxia. Steen is known to have sleep apnea but very compliant in using a CPAP so he is going to be placed on BiPAP. Steen's 02 sats were better on BiPAP but remain tachycardic at his respiration rate of 34. Steen's blood pressure was 70/40, which Dr. Garcia said could be partly from the morphine he received for pain, but could also be from sepsis as well. Steen was noted to be currently getting a normal saline IV bolus of 1,000 mls. It was charted that they would recheck Steen's ABGs later tonight to continue IV fluids and antibiotics, noting that Steen may need a PICC line in the am, and if Steen worsens, he may need mechanical ventilation.

140. On the same date at 2350 hours, **critical lab reports** result in and called into Dr. Garcia showing BiPAP 116/8 at 50%.

141. On the same date at 2355 hours, nursing notes reflect BP and urine output remain low. Dr. Garcia notified. A 1,000 mls bolus of Ringers Lactate started as per ordered.

142. On the same date at 2359 hours, Mark Daniel, RRT charts BiPAP in use. HR = 85, RR = 25, 02 sats = 97%.

143. On May 30, 2018 at 0003 hours, Dr. Garcia charts by progress note that Steen's blood pressure was still low at 87 systolic after receiving 1,000 mls bolus of normal saline IV. Dr. Garcia charts that he will give Steen a liter of Ringers Lactate and see if his BP improves. Dr. Garcia charts that if BP remains low, he will consider pressors. Dr. Garcia charts that Steen has a peripheral maintenance IV at 150/hour. Dr. Garcia documents that Steen's urine output is poor and his creatinine is 2.4H.

144. On the same date at 0015 hours, nursing notes reflect that Steen's BP improving with LR IV bolus. Steen was documented to be tolerating BiPAP well. Nursing chart that Steen remains tachypneic but denied respiratory distress.

145. On the same date at 0130 hours, nursing reflects that Steen had a small green bowel movement.

146. On the same date at 0200 hours, nursing notes reflect that Steen complained of right flank pain, and was medicated with 2 mg of IV morphine. At that point, Steen's blood pressure was in the low 90s. Dr. Garcia was notified and ordered Levophed.

147. On the same date at 0224 hours, Dr. Garcia charts by progress note that Steen's BP is still in the 80s after receiving two boluses of 1,000 mls. Will start Levophed drip and plan on inserting a PICC line in the am.

148. On the same date at 0336 hours, Stephen Marian, RRT charts that BiPAP in use. Heart rate = 72, RR = 35 and 02 sats = 98%.

149. On the same date at 0400 hours, nursing notes reflect that Steen was receiving Levophed drip and Steen's urine output remained low. It was charted that the call for PICC line insertion later that morning.

150. On the same date at 0530 hours, nursing notes reflect that Steen's BP was stabilized on Levophed and IV fluids continuing at 150/hour. MRSA swab repeated and sent to lab. Urine output remains low. Remains on BiPAP.

151. On the same date at 0629 hours, Mark Daniel, RRT charts BiPAP in use. HR = 88, RR = 28 and 02 sats = 97%.

152. On the same date at 0650 hours, nursing notes reflect Steen complaining of pain and medicated with IV morphine.

153. On the same date at 0700 hours, lab results were posted with the following abnormal findings: Cr = 3.05H, BUN = 48H, Glu = 53L, Cl = 117H, Co2 = 17L, Ca = 7.4L, WBC = 18.46 with Bandemia, H/H = 8.8L/27.4L, AST = 56H, Alb = 1.7L, and PT = 19.0H.

154. On the same date at 0720 hours, nursing notes reflect Steen's glucose level was 65. Steen was still NPO. Per protocol, Dextrose IV given and Dr. Charyalu (hospitalist-internal medicine) notified.

155. On the same date at 0740 hours, nursing notes reflect that Steen's glucose was now 135 and he was resting comfortably on BiPAP. BP stable on Levophed. Charted that IV Nurse Veros contacted for PICC line insertion.

156. On the same date at 0811 hours, nursing notes reflect that Steen was anxious and yelling that he needs his mask off. BiPAP removed and patient placed on six liters of

oxygen via nasal cannula which calmed Steen. Nurses document they were weening Levophed as BP tolerates. Nursing reflects lab showing positive blood culture result which was called to Kelly Sugarman.

157. On the same date at 0827 hours, lab results returned with ABGs with the following abnormal findings: Ph = 7.36, PC02 = 28L, PA02 = 74L, HC03 = 15.8L and 02 sats – 97.3%. The critical ABG results were called into PA Gogg.

158. On the same date at 0930 hours, nursing notes reflect Levophed drip off.

159. On the same date at 1040 hours, nursing notes reflect Dr. Watson, critical care physician and nephrologist at bedside discussing Steen's plan of care. Nursing notes reflect Steen was placed on a bedpan but did not have a bowel movement, only passing gas.

160. On the same date at 1105 hours, PA Benjamin Gogg, pulmonary medicine, notes that Steen has E-Coli bacteremia.[8] Steen was charted as saying he slept well last night and is very hungry and asking to advance his diet. Steen acknowledged passing gas and having bowel movement that day.

161. On the same date at 1110 hours, nursing notes reflect oral contrast ordered and started and CT technician notified.

162. On the same date at 1140 hours, nursing notes reflect patient incontinent of stool and patient had a large liquid brown stool. Steen and his bed were cleaned.

[8] Escherichia coli, also known as E. coli, is a Gram-negative, facultative anaerobic, rod-shaped, coliform bacterium of the genus Escherichia that is **commonly found in the lower intestine of warm-blooded organisms**. The systemic reaction to endotoxin (cytokines) or lipopolysaccharides can lead to disseminated intravascular coagulation and death.

163. On the same date at 1144 hours, Dr. Watson, general surgery, charts his progress notes that Steen's chief complaint is post-op right hemicolectomy now with probable localized leak. Dr. Watson ordered the nurses to send the patient to another hospital for an interventional radiology consult because the VA Hospital did not have an interventional radiologist to insert the percutaneous drainage.

164. On the same date at 1200 hours, nursing notes reflect Dr. Watson notified nurses that patient is being sent to Rowan Regional for further intervention. Dr. Watson notified the nurses that Steen would not need to complete the abdominal CT scan here and that it could be done at Rowan if they wish.

165. On the same date at 1244 hours, Olivia Hostetter, infectious disease resident and John Sanders, an infectious disease attending, chart that Steen was currently afebrile and no longer requiring pressors. Steen endorsed a good appetite, passing flatus and having bowel movements. Steen denied abdominal discomfort. Drs. Hostetter and Sanders charted that Steen's CT yesterday demonstrated some localized free air/fluid in the RUQ and subdiaphragmatic region potentially tracking to the anastomosis. Blood cultures were positive for E-Coli. Receiving Zosyn. Chart notes reflects that Steen's abdominal incisions were clean and clear and that Steen was with moderate distention but with no tenderness, rebound or guarding. It is charted that ID appreciated Dr. Watson's recommendation for percutaneous drain insertion by Dr. Capito at Rowan Regional. Dr. Hostetter notes that she discussed these findings with Dr. Sanders and he agrees with plan of care.

166. On the same date at 1249 hours, Dr. Watson charts that he reviewed Steen's overnight status with the ICU team. He charts Steen to be currently hemodynamically

stable and off pressors. Steen indicates that he is hungry. Charting Steen's only complaint is that his RUQ pain is more noticeable since yesterday. Dr. Watson charts vitals at that time of 120/50-98-18-95% on six liters of oxygen. Abdomen is charted as soft, tender to deep palpation. Dr. Watson charts that the CT scan official read from yesterday inconclusive regarding definite abdominal sores but does point out some localized free air/fluid in RUQ and the subdiaphragmatic region which Dr. Watson admits that he didn't appreciate last night. This appears to track to the area of the anastomosis. Blood culture positive x 3 for E-Coli. WBC = 18,000 with left shift. Hgb = 8.8. Urinalysis = negative. Dr. Watson's assessment was Sepsis/Septicemia. Most likely originating from an anastomotic leak **(hopefully contained**). Dr. Watson describes Steen as currently stable. Dr. Watson notes that this may be drainable/controllable with a percutaneous drain. Dr. Watson indicates that he has discussed this with Dr. Barr and Dr. Capito. Dr. Watson notes that Steen will undergo percutaneous drain placement by Dr. Capito at Rowan Regional within the next hour. If the drain placement is unsuccessful, Dr. Watson notes that Steen may need to be returned to the OR today for drainage and possible ileostomy diversion. If the drain placement is successful, will monitor him and take him to the OR should his condition worsen. Dr. Watson noted that Steen needed a PICC line for TPN but due to potential need for a dialysis he would need a central line.

167. On the same date at 1256 hours, nursing notes reflect that Dr. Watson's note containing his interpretation of the patient's 05/29/18 CT scan of the abdomen and chest on 05/29/18 were faxed to Novant-Rowan Medical Center (despite the fact that the CT

report dictated by the radiologist in California was available because Dr. Hostetter had read the radiologist's report at 1244 on 05/30/18).

168. On the same date at 1333 hours, nursing notes reflect that Rowan IR called and needed patient transported to Rowan ASAP. Per Dr. Watson, a CD with a copy of the patient's CT scan of the chest, abdomen and pelvis is to be sent with Rowan with patient.

169. On the same date at 1347 hours, Dr. Rabi Agarwala, pulmonary medicine, charts the Triple Lumen Central Line, inserted by Dr. Agarwala via the right subclavian vein.

170. On the same date at 1402 hours, radiology charts review of an x-ray showing that a right PICC line has been placed. The tip of the PICC line is at the Cavo atrial junction. No pneumothorax was seen. Radiology notes that chest is better seen on recent chest CT scan. It is charted that this x-ray was requested by Dr. Godofredo Garcia and the x-ray was interpreted by Dr. Jeffrey Neil.

171. On the same date at 1420 hours, nursing notes reflect that NuCare transport team at bedside ready to transport Steen to Rowan Regional Hospital.

172. On the same date at 1445 hours, nursing notes reflect that Steen left the ICU on stretcher on cardiac monitor with transport team.

173. On the same date at 1512 hours, Steven T. Sneed, M.D. at Novant Rowan Medical Center (hereinafter "RMC") ordered the CT scan interpretation of outside films.

174. Interestingly, it appears that the CT interpretation by the California radiologist, Dr. Andreia Grafton, appears not to have been transported with the patient to RMC.

175. On the same date at 1542 hours, PA-C Ashley Medina, at RMC, examined and evaluated the patient. PA-C Medina charts reviewing the history, ROS, medications, lab data, diagnostic studies that are mentioned and documented in this note. PA-C Medina discussed the case, management and formulated the plan with the advanced practitioner. An image guided placement of the right sided intrabdominal drainage catheter has been requested by Dr. Watson at VAMC. PA-C Medina charts that the labs from the VA Hospital were reviewed and all were in an acceptable range to safely proceed with the procedure – 139/65-99-24-98.4-99% on six liters of oxygen per nasal cannula. Steen is described as being alert and oriented with no focal deficits.

176. On the same date at 1547 hours, nursing notes at RMC reflect Steen to be oriented, and with shortness of breath with sinus tachycardia. Steen's abdomen is noted to be distended and rounded.

177. On the same date at 1603 hours at RMC, Steen is charted to have been given 3.374 grams of Zosyn IV.

178. On the same date at 1604 hours, nursing notes at RMC reflect that patient arrives to OR bay alert and orientated x 3. Steen is prepared for the procedure. Consent and allergies verified. At that time Steen's pulse was 100 and respirations were charted between 37 and 40, unlabored on oxygen via nasal cannula at six liters.

179. On the same date between 1605 to 1616 at RMC, Dr. Paul Capito, of interventional radiology, charted a diagnosis of sepsis-right upper abdominal abscess. Dr. Capito charts that his procedure of ultrasound guided drainage of right upper quadrant abdominal abscess. No anesthesia was administered during the procedure. An abnormal

collection of fluid was located in the lateral aspect of the RUQ of the abdomen. After insertion of a needle, purulent pus-like material flowed freely from the needle. Images taken during the procedure were stored for documentation. Dr. Capito charted dilatations up to a 12 French were performed and a 12 French all-purpose drain was coiled within the collection of fluid. Initially 40 mls of brown-yellow purulent fluid was removed. A specimen was sent to the lab for cultures. The JP drain was connected to the JP bulb to allow for continuous drainage. No complications were noted during the procedure. Vitals charted at 146/67-102-31.

180. On the same date at 1617 hours at RMC, Dr. Capito enters an order for abdominal drainage specimen to labs for culture, fungus, and smear abscess. Dr. Capito requested the results be sent to himself and the VA Hospital.

181. On the same date at 1620 hours, vital signs are charted at RMC as 152/69-100-32.

182. On the same date at 1622 hours at RMC, labs report on fungus culture and wound culture. No fungus isolated within the fungus culture. The wound culture showed moderate growth of Streptococcus anginous, moderate growth of Enterococcus faecium, moderate growth of Escherichia coli (E. col), heavy growth of Bacteroides theaiotaomicron, and moderate growth of Fusobacterium varium.

183. On the same date between 1624 and 1655 hours, RMC nursing notes reflect that Steen's procedure was completed, with 12 F JP bulb drain placed to RUQ. 39 mls of brown purulent fluid sent to lab via RN. Steen was charted to have tolerated the procedure well. Patient prepared for transfer to VA Hospital in Salisbury via stretcher. Vitals are

charted at 146/67-102-16-98%. Steen is described as oriented, with SOB, tachycardic and with round and distended abdomen. Vitals charted again as 161/71-101-20-98%. Nursing charts that attempts were made to call report to VA Hospital but unable to reach anyone by telephone at VA Hospital. Orders for after care were sent with patient to return to VA Hospital.

184. On the same date at 1703 hours at VAMC, Dr. Tushar, Dr. Vachharajani, nephrology, and Dr. Sean Godfrey, resident, chart their consult. The consult charts recent right hemicolectomy seen by nephrology for elevated creatinine and metabolic acidosis. Post operatively the patient developed an ileus, pleural effusion, AKI, and acidosis which resulted in the patient being transferred to the ICU. Steen was noted to develop hypotension requiring Levophed after failing to respond to three liters of IV fluid. Steen was prescribed Levaquin and Vancomycin but is now on Zosyn. Steen denied any prior kidney complications and as charted overnight Steen had adequate urine output (300 mls since 0600). Steen was also charted to have passed gas and had a bowel movement. It is charted that Steen's abdomen was distended, tympanic and with hypoactive bowel sounds. Review of the chest x-ray showed possible right LLL pneumonia and/or atelectasis with new small right pleural effusion. It was also charted that Steen may have severe narrowing of the trachea, or tracheobrochomalicia. It was charted that Steen had an embolized radiation seed from his prostate cancer in his right middle lobe. A review of the CT scan of the abdomen and pelvis show Steen was status port-right hemicolectomy with ileocolic anastomotic suture in the RUQ. CT showed moderate amount of pneumoperitoneum in the right prehepatic region extending into the subdiaphragmatic region and tracking adjacent to the

ileocolic anastomotic suture along the right lateral abdominal wall with associated moderate amount of free fluid in the right abdomen and pelvis. It was charted that these findings may be consistent with the post-surgical etiology however, an ileocolic anastomotic leak cannot be excluded especially in the setting of sepsis. It was charted that there was clinical concern for an anastomotic leak and a CT scan with contrast of the abdomen and pelvis should be considered. CT also documented the evidence of the small bowel post-op ileus. CT documented the bladder wall has thickened which may be secondary to incomplete distention, trabecular hypertrophy, or inflammatory/infectious cystitis. Again it was noted that these findings were discussed by the radiologist with Dr. Garcia at 2040 hours on 05/29/18. Consult team's assessment was AKI – likely due to hypotension or hypoperfusion. It was charted that Steen was not a candidate for dialysis at that time. Assessment included Septicemia of unclear source and it was charted that blood culture was positive for E-coli and Enterobacter x 3 bottles. It was noted to continue antibiotics.

185. On the same date at 1714 hours, Dr. Vachharajani charts again after review of Steen's records that Steen's creatinine had increased overnight from 1.8 to 2.0 to 3.0. Steen's urine output was roughly 60 – 70 mls/hour. Dr. Vachharajani noted that given Steen's underlying chronic kidney disease and other co-morbidities, Steen had a very high probability of advancing to end stage renal disease.

186. On the same date at 1740 hours at VAMC, Steen was charted to have returned to the ICU from Rowan Hospital with new JP drain and abdomen draining purulent fluid.

Steen was described as being hungry and wanting to eat. Steen was informed that while he was NPO they were advising that he could have ice chips.

187. On the same date at 1812 hours, Dr. Watson charts a progress note describing Steen back from Rowan Regional Hospital and discussion with Dr. Capito. It was noted that a drain was placed under ultrasound guidance and a complex fluid collection was observed and 50 mls of frank pus (not bilious/enteric fluid) was aspirated. JP draining bulb now almost full of additional purulence (approximately 75 mls). It was described as Steen noted an immediate improvement in pain after JP drain placement. Vital signs at that time were reported as 120/65-95-15-98%. Steen's abdomen was described as soft and non-tender, and it was described that Steen had 200 mls of urine output since going to Rowan Regional. Dr. Watson's assessment was that of an apparent successful percutaneous drainage of subdiaphragmatic abscess from possible contained anastomotic leak versus infected fluid collection. Dr. Watson discussed with Dr. McIltrott, who was covering surgical care this evening. Dr. Watson charted that he appreciated all the consultants' help. Dr. Watson's plan was to continue NPO, antibiotics, IV hydration and monitor electrolytes. Start TPN tonight.

188. On the same date at 1830 hours, nursing notes reflect patient forgetful and still asking if he can have dinner. TPN started.

189. On the same date at 2000 hours, nursing notes reflect telemetry showing sinus tachycardia with HR of 104. Triple Lumen Central Line in place with multi-vitamin bag infusing. Foley was described as having yellow cloudy urine. Oxygen sats at 97% with

six liters of oxygen via nasal cannula. Respiratory rate equal to low to mid-30s. JP drain described with green drainage. Surgical abdominal wounds healing without difficulty.

190. On the same date at 2200 hours, nursing notes reflect that patient had a greenish liquid stool. JP drain was also described with 40 mls of green liquid output.

191. On the same date at 2240 hours, nursing notes reflect that Steen complained of 7/0 abdominal pain and he was given 2 mg of morphine IV for pain.

192. On the same date at 2330 hours, nursing note reflects that Steen states his abdominal pain is now 4/10 after receiving morphine.

193. On May 31, 2018 at 0200 hours, nursing notes reflect JP drain produced 7.5 mls of yellowish-green drainage.

194. On the same date at 0240 hours, nursing notes reflect that Steen has complained of 10/10 abdominal pain and he was given 2 mg of morphine IV for pain.

195. On the same date at 0555 hours, nursing notes reflect that the lab called to report critically low calcium level. Dr. Garcia called regarding critically low calcium level.

196. On the same date at 0700 hours, labs were reported with the following abnormal findings: WBC = 13.7H with Bandemia, H/H = 8.2L/25.2L, Cr = 3.38H, BUN = 51H, Ca = 6.8L, C02 = 17L, Na = 148H, Glu = 148H, AOKPh = 130H, AST = 67H and PT = 19H.

197. On the same date at 0900 hours, nursing notes reflect patient and NPO status discussed with Dr. Watson at bedside. Patient is to remain NPO for the time being until the drainage and the JP drain from the abdomen clears up and then clear liquids can be restarted.

198. On the same date at 1035 hours, Dr. Jennifer Andrews, General Surgery resident, and Dr. Watson, general surgeon, at bedside. They chart JP drain output is now more green/yellow in character. Color of JP drainage is now more consistent with an anastomotic leak. Patient is stable but improving. Will continue to monitor. No other acute events overnight. Steen's pain reported to be dramatically improved since his JP drain was placed yesterday. Steen is reported to have some mild episodes of confusion overnight. Steen had one small bowel movement overnight. TPN was started yesterday. Abdomen was described as soft and non-distended. Steen was described as may be having ICU delirium. Charting reflects to keep Steen NPO. Steen's creatinine level was described as seeming to be plateauing, and Steen was with great urine output. Continued Foley with strict I&Os. Continue Zosyn with concern for leak and positive blood cultures. Appreciate ID recommendations. Continue to monitor JP drainage.

199. On the same date at 1136 hours, Sean Godfrey, DO, nephrology resident, consults on Steen, describing seeing and examining Steen that morning. Dr. Godfrey notes that Steen tolerated having JP drain placed yesterday and overnight. Vital signs described as stable and he is afebrile. Steen's urine output was described as good with roughly 75 mls per hour. (500 cc at 0600). Steen described himself as doing okay and that his abdominal pain is tolerable that morning. Steen's abdomen is described as distended, tympanic with hypoactive bowel sounds. Kidneys are approaching euvolemic status. Steen's creatinine was described as increasing despite his urine output. Dr. Godfrey charts to avoid nephrotoxins, charting that he could use Vancomycin per pharmacy. Dr. Godfrey charts discussing this case with his attending, Dr. Vachharajani.

200. It is unclear from the chart when surgical pathology from the May 21, 2018 surgery was posted. Ultimately the surgical pathology reports on the pathological specimens. The surgical specimens in pathology included right colon, terminal ileum, appendix, cecum, and ascending colon with stapled margins. Pathology's diagnosis was of signet ring adenocarcinoma, lymph/vascular invasion identified, pT3NO. Tubulovillious adenoma with high grade dysplasia. Poorly differentiated. The specimens were described all with clean margins. Twenty-two lymph nodes with zero involvement.

201. On May 31, 2018 at 1200 hours, nursing notes reflect that Steen was placed on a bedpan but unable to move bowels and only passed gas. A small amount of purulent drainage noted from midline abdominal surgical incision. No complaints of pain. Patient is requesting something to eat. Reminded that he is NPO until Dr. Watson changes his orders.

202. On the same date at 1308 hours, Dr. Vachharajani, nephrology, charts by consult note that Steen underwent abdominal drain placement by IR at Rowan Hospital with frank pus draining out. Now Steen with JP drain. Steen was described with large watery BM last night. Steen was described as comfortable when lying flat. Vital signs are stable with frequent PVCs and bigeminy noted on his cardiac monitor. Urine output 80 mls per hour. Steen was started on TPN at 43 ml/hour. CR = 3.3, K = 3.5, C02 = 17, Na = 148. Dr. Vachharajami's assessment was of acute kidney injury in patient with chronic Stage III non-oliguric kidney disease. Avoid hypotension, volume depletion and nephrotoxic medications. Mild hypernatremia. Hyperchloremia with mild metabolic acidosis – use chloride-free replacement fluid.

203. On the same date at 1400 hours, nursing notes reflect that Dr. Watson rounded and was shown drainage from JP drain and midline incision. Dr. Watson opened the incision and decided it was best to take the patient back to surgery. Opened incision was charted by nursing to be packed with wet saline soaked 4 x 4s and covered with dry 4 x 4s.

204. On the same date at 1440 hours, nursing notes reflect PA Gogg at bedside. PA Gogg was notified that Dr. Watson is taking the patient back to surgery and that patient is having more frequent PVCs and sometimes bigeminal PVCs. Orders received for an EKG and blood work.

205. On the same date at 1453 hours, Dr. Watson charts as a progress note of Steen, charting Steen's condition has changed since he was seen that morning. Dr. Watson described seeing the patient this afternoon on rounds complaining of more generalized upper abdominal discomfort along with midline incision tenderness. Steen was described as remaining afebrile. RR = 20-25, pulse = 95, BP = 126/80. Urine output has been good. Generally he looks worse compared to this morning and is less alert. Steen's abdomen is now tender in the upper quadrant and left quadrants. Steen's midline incision is indurated and has erythema. Glue peeled off and skin opened revealing purulence in SubQ space. Dr. Watson described the fascia as being intact but purulence seems to be emanating from abdominal cavity between sutures. No change noted in JP drain output. Dr. Watson noted that given the worsening clinical appearance along with abdominal exam and wound findings, it appears that the JP drain has failed to control the source. Dr. Watson recommended to the patient and his family that he be returned to the OR immediately for

re-exploration along with a diverting ileostomy. Dr. Watson advised against an attempt at re-section and re-anastomosis due to Steen's risk for complications due to his septic/malnourished states.

206. On the same date at 1510 hours, nursing notes reflect that Dr. Ararwala at bedside, with patient with Steen complaining of pain especially when his abdomen is manipulated. Nurses chart that an MD was notified, also noting that a prn dose of morphine 2 mg/IV was given about an hour ago.

207. On the same date at 1520 hours, nursing notes that the infectious disease team and anesthesia at bedside. They were notified that Dr. Watson is taking the patient back to surgery.

208. On the same date at 1535 hours, nursing notes reflect that the patient left the ICU to OR.

209. On the same date at 1556 hours, PA-C Gogg, pulmonary medicine, charts consult note that Steen's diagnosis is E-Coli Bacteremia, charting Steen describing increasing pain throughout the day and in sleeping poorly last night. Steen's abdomen is described as distended and tender to palpation consistent with increasing bowel gas. PA-C Gogg's assessment was of status post-colostomy takedown, with blood cultures positive for E-Coli and Enterobacter. Hypotension resolved status post-three liters of normal saline and two liters of Ringers Lactate, placed on Levophed. PSA-C Gogg described that Steen was off Levophed this morning, central line inserted and placement verified. Steen currently on Zosyn per nephrology due to kidney status. No Vancomycin or Levaquin. Bilious purulent fluid output today in JP drain. Culture of drainage sent to lab. Will return

to the OR with Dr. Watson this afternoon. PA-C Gogg also describes Steen has having hypoventilation syndrome and that Steen suffered from moderate hypoxia last night. Steen was noted to have no BiPAP today. It was noted that the CT of the thorax shows moderate bilateral atelectasis. PA-C Gogg charted to hold BP meds today.

210. On the same date at 1612 hours, Dr. Olivia Hostetter, infectious disease, charts a consult for sepsis. Dr. Hostetter's note indicates the patient complains of generalized upper abdominal pain. Vital signs stable, afebrile with good urine output. Steen states his pain is tolerable and appears less awake this morning; however, he does respond to questions and is oriented. Dr. Hostetter noted that Steen's JP drain is producing purulent drainage. Hostetter noted that Steen seems to be comfortable, pleasant but more sleepy today than on prior interviews. Steen was noted to have tenderness to palpation over his abdomen, which was worse in the RUQ and LUQ. Dr. Hostetter noted that Steen's midline incision has purulent drainage through the subcutaneous space. Steen was noted to be on IV Zosyn. Dr. Hostetter reviewed labs and images and arrived at a diagnosis of E-Coli sepsis with positive blood cultures. Steen's percutaneous drain appears to be failing to resolve the infected fluid collection since he now has purulent material oozing from his abdominal cavity. Dr. Hostetter noted that if there was a plan for surgery to please obtain wound cultures.

211. On the same date at 1925 hours, nursing notes reflect that the patient returned to the ICU from the OR. Dr. Garcia was paged for orders as patient has been hypotensive requiring BP support and not had current orders for sedation.

212. On the same date at 1933 hours, Dr. Watson's operative report reflects that his assistant for the procedure was Ken Lipshy, M.D. Dr. Watson describes a diagnosis of an intra-abdominal sepsis due to an anastomotic leak with feculent peritonitis in the right upper quadrant. Dr. Watson's findings were of a failure of suture line at closure of common enterotomy from side-to-side anastomosis. Dr. Watson found no evidence of ischemia. Dr. Watson found feculent contamination fairly localized in the right lateral abdomen and subdiaphragmatic space. Dr. Watson noted dense post-operative adhesions. Dr. Watson described the procedure as an emergency exploratory laparotomy, re-section of the ileocolonic anastomosis and creation of a diverting end ileostomy and insertion of a flat JP drain in the right subdiaphragmatic space. Specimens from the procedure included an ileocolic anastomosis and culture of abdominal contamination. The operative notes that the patient was already receiving Zosyn pre-operatively. It was noted that Steen did require vasopressor support at the beginning of that surgery. Operative report reflects the midline incision was extended to just below the ziphoid process. There were dense adhesions. It was charted that it appeared the VLOCK suture had completely failed. Post-operatively Steen was returned to the ICU intubated and on a ventilator. It was noted that Steen did not need vasopressor support at the conclusion of the surgery. Surgical time was listed from 1610 to 1912 hours.

213. On the same date at 1946 hours, nursing notes reflect NG tube connected to low suction. Awaiting orders from physician.

214. On the same date at 1947 hours, Timothy Hanley, RRT charted that Steen to be on ventilator. BP = 135/60, HR = 106, RR = 20 and 02 sats = 92%. Steen was described

as being agitated and Steen was described as producing a large amount of thick yellow sputum upon his return to the OR.

215. On the same date at 2000 hours, nursing notes reflect that Steen received an ICU from the OR. Steen was noted to be intubated with no signs of respiratory difficulty. Steen was still sedated, with large bulky dressings to mid-abdomen with spotted drainage. The charting reflected a new JP drain to the RUQ of abdomen with sanguineous drainage. Ileostomy draining dark green fluid. NG tube tubed to low suction. Foley catheter in place. Soft limb restraints applied to upper extremities. Good radio pulses. Triple lined catheter in the right subclavian. Peripheral IV in the left antecubital vein.

216. On the same date at 2026 hours, Dr. Watson wrote progress note that he discussed the case findings with Dr. Garcia along with surgical plan to give two units of PRBCs, insert an NG tube, give antibiotics, and monitor stoma. Recommended trying to wean the patient from the ventilator in the morning. Dr. Garcia has agreed to assist with ventilator/sedation management this evening. Also discussed with Dr. Moore who would be covering for Dr. Watson this evening.

217. On the same date at 2036 hours, Dr. Garcia charted notes that restraints ordered to keep patient from pulling out his IV lines and tubes.

218. On the same date at 2125 hours, nursing notes reflect that Steen was becoming restless, remained intubated and with soft wrist restrains in place. Propofol drip started.

219. On the same date at 2145 hours, nursing notes reflect Steen's blood pressure was 82/49 and the Propofol drip rate was decreased.

220. On the same date at 2140 hours, labs are charted as notifying Dr. Garcia of critical blood gas result – 65% FiO2.

221. On the same date at 2155 hours, Dr. Garcia, internal medicine – hospitalist, charts to briefly discuss the case with Dr. Watson after patient was brought back from OR to the ICU. Intraoperatively, Steen was found to have an anastomotic leak with peritonitis. Resection occurred with the creation of a diverting end ileostomy. Steen is on ventilator and orders for restrains were placed and Propofol drip was started for sedation. Steen was noted to be NPO and is on TPN as well as antibiotics. Steen ABG done a few minutes ago was consistent with metabolic acidosis (pH = 7.18, PC02 = 34, P02 = 75, HC03 = 12.7). Dr. Garcia charted will order 100 mEq of bicarb now and start a new NaHC02 drip.

222. On the same date at 2221 hours, labs were entered, ABGs with the patient on a ventilator as follows: pH = 7.18L, PC02 – 34L, P02 = 76L, HC03 = 12.7L, 02 sat = 95.8%.

223. On the same date at 2330 hours, nursing notes reflect pre-transfusion vital signs as follows: 65/50-109-17-97.3. Unit No. 1 of PRBCs started.

224. On the same date at 2244 hours, Dr. Garcia charts, per nurse his BP is now 76/56 and Steen was on a Propofol drip which was decreased, but Steen's blood pressure remains low. Dr. Garcia charts that he will try a 500 ml bolus of normal saline to see how Steen responds.

225. On the same date at 2245 hours, nursing notes reflect Steen with the following vitals: 59/49-110-24-97.8. Nurses chart the Propofol drip decreased with much effect.

226. On the same date at 2250 hours, nursing notes reflect Steen's blood pressure at 65/33 and Dr. Garcia called and informed. 500 mls of normal saline IV bolus started. Propofol stopped. Patient placed in Trendelenburg position.

227. On the same date at 2255 hours, nursing notes reflect Steen's vital signs at 55/43-105-14-97.2.

228. On the same date at 2355 hours, nursing notes reflect second 50 mEq of bicarb given IV per MD orders.

229. On June 1, 2018 at 0005 hours, nursing notes reflect that Dr. Garcia called for Steen's blood pressure of 74/35.

230. On the same date at 0011 hours, Dr. Garcia charts patient received 1,000 mls IV fluid bolus and his BP still remains low at 74/35. Will try one more 1,000 mls IV bolus and if there is no improvement will start a Levophed drip. Nursing charts 1,000 ml IV bolus started at that time.

231. On the same date at 0055 hours, nursing notes reflect Steen's vitals as 63/43-107-18-97.5.

232. On the same date at 0150 hours, nursing notes reflect Steen's pre-transfusion vital signs at 58/47-100-14-97.6 and Steen was started on a second unit pf PRBCs.

233. On the same date at 0205 hours, nursing notes reflect Steen's vital signs at 52/41-107-11-97.7.

234. On the same date at 0206 hours, Dr. Garcia charts Steen's BP still low in the 70s systolic and will start Levophed.

235. On the same date at 0230 hour, nursing notes reflect Nor-epi drip started.

236. On the same date at 0300 hours, nursing notes reflect that Steen's BP to be 62/46 and Nor-epi drip increased.

237. On the same date at 0305 hours, nursing notes reflect Steen's vitals at 70/55-111-11-98.0.

238. On the same date at 0405 hours, nursing notes reflect Steen's vitals as 98/82-111-19-97.9.

239. On the same date at 0545 hours, nursing charts that Dr. Garcia making rounds in the ICU and update provided to Dr. Garcia. Orders for ABGs to be repeated.

240. On the same date at 0554 hours, labs posted that the labs-ABG with patient on a ventilator with pH = 7.35, PC02 = 23L, P02 = 96 and HC03 = 12.7L with 02 sats at 99%.

241. On the same date at 0600 hours, nursing notes reflect Steen's Glu = 108. Steen was noted to be NPO with his insulin held. Steen noted to be oliguric = only 75 mls of urine during shift.

242. On the same date at 0615 hours, labs chart Dr. Charyalu notified of critical ABG results.

243. On the same date at 0730 hours, Dr. Watson charts that Steen was seen on rounds, and he notes his agreement with the resident's assessment that Steen needs to be transferred, as Steen's critical care needs exceed the current capabilities of VAMC.

244. On the same date at 0733 hours, surgical pathology charts the findings for surgical pathology specimen – terminal ileum and ileocolonic anastomosis in segment of resected bowel, with surgeon Dr. Kevin Watson (general surgery), surgery performed on

05/31/18. Pathology reports segment is a segment of bowel 70 centimeters in length. Approximately 13 centimeters for the distal margin is in apparent perforation with surrounding exudate. Attached to the perforation are numerous sutures. The perforations contiguous with the colonic anastomosis. Serosa distal to the perforation is markedly thickened and covered by tan firm fibrotic exudate-plaque. The additional fragment of small bowel was submitted with the attached lymph nodes. There are cells representing tumor within the wall of the ileum near the anastomosis. Pathology diagnosis was of focal signet ring cell adenocarcinoma present within the ileal wall near the anastomosis. Perforation of the ileal colonic anastomosis site with the associated chronic and acute inflammation and serosal exudate. No evidence of metastasis in seven regional lymph nodes. However, the pathologist feels the signet ring cell carcinoma within the wall represents a metastatic focus.

245. On the same date at 0740 hours, nursing notes reflect Dr. Watson to be rounding in the ICU and updated on patient's condition overnight.

246. On the same date at 0807 hours, Dr. Watson added an addendum to his earlier progress note. Dr. Watson charted that Steen had been hypotensive overnight despite two units of PRBCs along with several IV fluid boluses. Steen now on 50 mcg of vasopressor. Remains on ventilator. 02 sats = 93%. Intubated but did not tolerate Propofol and became hypotensive. Urine output 75 mls for entire prior shift. JP drainage has minimal serosanguinous drainage. Stoma output equal to 1,100. NG tubs drainage = 650 mls. Midline incision intact. To continue IV fluid, antibiotics, and ventilator support. Dr. Watson's assessment is SIRS with worsening AKI status post-surgery yesterday for

intrabdominal sepsis for anastomotic leak. Discussed transfer of patient to another facility with PA Goff of infectious disease since patient is likely to require dialysis given his hypotension that is non-responsive to treatment.

247. On the same date at 0829 hours, nursing notes reflect patient ventilated without problems on sedation. PA-C Gogg notified of patient's critical status and overnight events and need for evaluation orders. Will continue to monitor closely.

248. On the same date at 0834 hours, lab notes that Dr. Ravi Agarwala notified of critical calcium result (6.2).

249. On the same date at 0843 hours, PA-C Gogg from infectious disease charts unable to send the patient to Atrium network hospital by air ambulance because there are no beds available in the Atrium network. Will contact Novant-Presbyterian.

250. On the same date at 0925 hours, Timothy Hanley, RRT notes Steen to be intubated and agitated on ventilator. Hr = 113, RR = 38, 02 sats = 97%.

251. On the same date at 1031 hours, labs note Kelly Sugarman notified of positive blood culture result for E-Coli.

252. On the same date at 1032 hours, there is a discharge summary entered by PA-C Benjamin Gogg and Charles De Comarmond, M.D. of infectious disease who charts Steen has a diagnosis of sepsis with septic shock, acute renal failure, adult hypoventilation syndrome, and diabetes. Summary reads that Steen had an uncomplicated three day (change from six days) post-op recover on the floor before presenting febrile and severely hypotensive on 05/29/118 with corresponding lab values consistent with sepsis. CT scan of the abdomen showed a small anastomotic (detachment from the colostomy takedown)

procedure. Steen was sent to Rowan Regional Hospital for JP drain placement by an interventional radiologist. When he returned to the VA Hospital, he was placed on Zosyn because there was concern about Vancomycin causing further kidney impairment. His creatinine continued to decline to 3.5 on 05/31/18 and he was returned to the OR for an exploratory laparotomy with extensive peritoneal lavage. He was returned to the ICU intubated and sedated with Propofol on a ventilator. Overnight his BP was non-responsive to IV fluids boluses and he was started on Levophed and given bicarb to correct his metabolic acidosis. Due to his declining renal performance with a CR of 4.5 and a WBC of 18 with Bandemia and SPV hovering in the mid-80s, Presbyterian ICU in Charlotte was contracted for transfer and he was accepted. All records were sent with patient to Presbyterian Hospital.

253. On the same date at 1045 hours, nursing notes reflect that transport team arrived. Surgery resident at bedside changing abdominal packing/dressing. Levophed drip increased to 15 mcg/min.

254. On the same date at 1104 hours, Dr. Hostetter (resident) and Dr. Bajillan of infectious disease charts at POD No. 7 the patient had a sudden decline in his clinical status (hypoxia and metabolic acidosis). He was transported to the ICU and placed on BPAP and broad-spectrum antibiotics due to concern for sepsis. His pneumonia or his abdomen were soon to be the likely source of his sepsis as he recently had abdominal surgery. Blood cultures were obtained before starting antibiotics and were found to be positive for E-Coli. Steen's 05/29/18 CT scan demonstrated some localized free air/fluid in the RUQ and subdiaphragmatic region that potentially trapped the area of his anastomosis. Blood

cultures have been positive x 3 for E-Coli. A percutaneous drain was placed on 05/30/18. IV Zosyn started instead of Vancomycin due to concern for renal impairment. On 05/31/18 he was returned to the OR for an emergency laparotomy and extensive peritoneal lavage. Steen was noted to be sedated and on the ventilator continued soft vasopressors, with plan to transfer to Presbyterian ICU for dialysis.

255. On the same date at 1125 hours, nursing notes reflect Steen left ICU with Transport Team for Presbyterian Hospital in Charlotte.

256. On the same date at 1202 hours, physician progress note by Dr. Jennifer Andrews-General Surgery Resident (Cosigned by Dr. Kevin Watson at 14:37) summarized care of Steen. Now POD#1 of exploratory lap due to worsening clinical status in afternoon. Anastomotic leak and feculent peritonitis noted during surgery. Diverting ileostomy created. Overnight he require 15 of Levophed and had tachycardia in the 110s. Steen received an additional 3 liters of crystalloid, 2 units of PRBCs since the OR. A bicarb drip was started as well for metabolic acidosis. Steen remained on a ventilator overnight. His urine output dropped significantly to 75 mls since his surgery with a rising creatinine. Plans made to transfer the patient to Presbyterian Hospital today for additional critical care needs. Steen's lactic acidosis worsening, his abdomen is soft and nondistended, his midline incision is packed with Kerlex and retention sutures are in place. There is no incisional drainage, and his fascia is intact. His right sided ileostomy is producing a green liquid. His stoma is pink but there is some sloughing around the edges. His RUQ JP drain has tan drainage. His old port sites are closed with Dermabond. The plan was for Steen to be transferred to Novant-Presbyterian in Charlotte for additional critical care.

DAMAGES

257. As a result of the negligence of the Defendant, by and through its agents and employees as described herein, Steen suffered an extended delay in care as a result of a failure to act on clear medical indications of an anastomotic leak. Such delay in appropriate care allowed the source of Steen's sepsis to continue uncontrolled and to drastically worsen, leading to a critical threat to Steen's life. Such delay in appropriate care was a proximate cause of Steen's need for transfer to the ICU of a non-VA facility for more acute care, including an extended period of intubation, where extensive medical care, rehabilitation and medical expenses were incurred in saving Steen's life. Such delay in appropriate care was a proximate cause of Steen's significant peritonitis, worsening sepsis, acute organ failure, renal failure, and ileostomy. Such delay in appropriate care was a proximate cause of Steen's period of six-month total debility, and his resulting permanent loss of function.

FIRST CAUSE OF ACTION
(Medical Negligence – Violation of the Standard of Care)
(Kevin Whittington Watson, MD)

258. The allegations contained in Paragraphs 1 through 256 are re-alleged and incorporated by reference as if fully set forth herein.

259. Defendant USA, by and through Dr. Watson and other unnamed agents and employees, was negligent, and this negligence was a proximate and reasonably foreseeable cause of pain and suffering and significant injury suffered by Steen. Defendant breached its duty to care for and treat Steen using reasonable and ordinary care in accordance with

the skill, training, and experience of a physician practicing medicine in the same or similar community in that they:

(a) failed to act when Steen presented with emergent medical needs, with a clear anastomotic leak, that required immediate action, immediate re-opening for surgical exploration and washout, when such a failure to act caused deterioration of Steen's health and significant irreversible loss of function;

(b) failed to reopen Steen on or before May 29, 2018 when Steen had a clinical presentation consistent with anastomotic leak;

(c) failed to reopen Steen on or before May 29, 2018 when Steen had presentation by CT scan consistent with anastomotic leak;

(d) incorrectly read the Steen May 29, 2018 CT Scan;

(e) failed to review, or timely review, the Steen May 29, 2018 CT Scan radiology report;

(f) failed to obtain a contract-enhanced CT of the abdomen and pelvis for further evaluation of anastomotic leak;

(g) failed to consider Steen's declining clinical presentation as from anastomotic leak requiring emergent surgical exploration with washout;

(h) delayed emergent critical care to Steen by sending Steen out to Novant Health Rowan Medical Center for drain placement;

(i) failed to recognize the emergent need for emergent reopening of Steen after Steen's sepsis was determined to be E-Coli in origin:

(j) failed to act and provide care to Mr. Burgess in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged acts giving rise to this cause of action;

(k) failed to exercise reasonable care and diligence in the application of their knowledge and skill to Mr. Burgess' case; and

(l) failed to use their best judgment in the care and treatment of Mr. Burgess.

260. As a direct and proximate result of Defendant's negligence, as herein alleged, Steen endured extended pain and suffering; and was caused to suffer such injuries and damages as set forth herein.

SECOND CLAIM FOR RELIEF
(Common Law Negligence)
(Kevin Whittington Watson, MD)

261. The allegations contained in Paragraphs 1 through 259 are re-alleged and incorporated by reference as if fully set forth herein.

262. Defendant USA, by and through Dr. Watson and other agents and employees, owed Steen a duty to care for him in compliance with the common law. Under the common law of North Carolina, a physician or health care provider must (1) possess the degree of professional learning, skill, and ability which others similarly situated ordinarily possess; (2) exercise reasonable care and diligence in the application of his or her knowledge and skill to the patient's case; and (3) use his or her best judgment in the treatment and care of the patient.

263. Defendant USA, by and through Dr. Watson and other agents and employees, were negligent, and their negligence was a proximate and reasonably foreseeable cause of pain and suffering and permanent injury suffered by Steen, as described herein.

264. Defendant USA, by and through Dr. Watson and other agents and employees, breached their common law duties of care owed to Steen in that they did not: (1) exercise reasonable care and diligence in their application of their knowledge and skill to Steen's care and (2) use their best judgment in the treatment and care of Steen.

265. As a direct and proximate result of Defendants' negligence, that negligence through Dr. Watson and other agents and employees, as herein alleged, Steen endured extended pain and suffering; and was caused to suffer such injuries and damages as set forth herein.

THIRD CLAIM FOR RELIEF
(Medical Negligence – Violation of the Standard of Care)
(Godofredo Igno Garcia, MD)

266. The allegations contained in Paragraphs 1 through 264 are re-alleged and incorporated by reference as if fully set forth herein.

267. Defendant USA, by and through Dr. Garcia and other agents and employees, was negligent, and this negligence was a proximate and reasonably foreseeable cause of pain and suffering and significant injury suffered by Steen. Defendant breached its duty to care for and treat Steen using reasonable and ordinary care in accordance with the skill, training, and experience of a physician practicing medicine in the same or similar community in that they:

(a) failed to take immediate action after receiving **"SIGNIFICANT ABNORMALITY, ATTN NEEDED"** and **"CRITICAL ABNORMALITY"** CT radiology oral report by Andreia Grafton, M.D., provided to him with read back verification at 2040 hours on May 29, 2018;

(b) failed to chart the discussion held with Dr. Andrea Grafton of the critically significant abnormal CT findings of Steen;

(c) failed to immediately contact Dr. Watson to advise him of the significant abnormal findings of the CT scan relayed by Dr. Grafton;

(d) failed to immediately order a contrast-enhanced CT scan of the Steen abdomen and pelvis for evaluation of the anastomotic leak;

(e) failed to act and provide care to Steen in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged acts giving rise to this cause of action;

(f) failed to exercise reasonable care and diligence in the application of their knowledge and skill to Steen case; and

(g) failed to use their best judgment in the care and treatment of Steen.

268. As a direct and proximate result of Defendant's negligence, as herein alleged, Steen endured extended pain and suffering; and was caused to suffer such injuries and damages as set forth herein.

FOURTH CLAIM FOR RELIEF
(Common Law Negligence)
(Godofredo Igno Garcia, MD)

269. The allegations contained in Paragraphs 1 through 268 are re-alleged and incorporated by reference as if fully set forth herein.

270. Defendant USA, by and through Dr. Garcia and other agents and employees, owed Steen a duty to care for him in compliance with the common law. Under the common law of North Carolina, a physician or health care provider must (1) possess the degree of professional learning, skill, and ability which others similarly situated ordinarily possess; (2) exercise reasonable care and diligence in the application of his or her knowledge and skill to the patient's case; and (3) use his or her best judgment in the treatment and care of the patient.

271. Defendant USA, by and through Dr. Garcia and other agents and employees, were negligent, and their negligence was a proximate and reasonably foreseeable cause of pain and suffering and permanent injury suffered by Steen, as described herein.

272. Defendant USA, by and through Dr. Garcia and other agents and employees, breached their common law duties of care owed to Mr. Burgess in that they did not: (1) exercise reasonable care and diligence in their application of their knowledge and skill to Steen's care and (2) use their best judgment in the treatment and care of Steen.

273. As a direct and proximate result of Defendants' negligence, that negligence through Dr. Garcia and other agents and employees, as herein alleged, Steen endured extended pain and suffering; and was caused to suffer such injuries and damages as set forth herein.

WHEREFORE, Plaintiff demands judgment against Defendant United States of America for compensatory damages in an amount which will adequately compensate Plaintiff Foster Steen's personal injury, past and future medical expense, plus interest and costs, and any and all other relief to which the Plaintiff may be entitled.

This the 29th day of May, 2022.

Respectfully submitted,

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